

Units (PU) in Spain, and to determine possible differences according to aetiology. **METHODS:** Consecutive NeP patients were recruited in this cross-sectional & retrospective study between April and December 2004 in PUs. Demographic data, NeP type and cause, origin of the derivation, and health resources consumption (drugs, non-pharmacological therapies, medical visits, hospitalizations, diagnostics tests) were collected from existing medical records and patient interview. Costs of resources at their 2004 values were applied to calculate total cost from the National Health System perspective. Descriptive statistics and ANCOVA models were used. **RESULTS:** Five-hundred-four NeP patients of broad aetiology (44% radiculopathy, 21% neuralgias, 11% neuropathies, 7% entrapment syndromes, 5% CRPS, 4% central pain), 57.8 ± 0.7 years (Mean ± SE), 57.6% women, and 29.6 ± 2.2 months of evolution, were enrolled in the study. Unadjusted monthly average cost was 422 ± €36. Adjusted monthly cost was significantly higher than average for neuropathies (580 ± €90,  $p = 0.011$ ), because of the higher number of hospitalization days (0.6 ± 0.1,  $p = 0.021$ ) and pharmacologic costs (162 ± €17,  $p = 0.001$ ). Radiculopathies showed lower adjusted costs than the average; €287 ± €46,  $p = 0.026$ , because of the lower cost of hospitalization; €79 ± €38,  $p = 0.027$ . **CONCLUSIONS:** NeP causes a considerable utilization of health resources with a substantial cost for the National Health Service. Neuropathies showed the higher cost per month per patient, whereas that of the radiculopathies was significantly lower than the average.

PPN5

#### **A MODEL-BASED COST-UTILITY ANALYSIS OF LYRICA™(PREGABALIN) VERSUS CURRENT PHARMACEUTICAL MANAGEMENT OF PERIPHERAL NEUROPATHIC PAIN**

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**OBJECTIVES:** To assess the cost per QALY of pregabalin in the management of peripheral neuropathic pain. **METHODS:** We compared pregabalin on top of "usual care" with "usual care" alone. In this study usual care was defined as a mix of drug therapies, excluding anti-epileptics, because the latter represented only 9% of current use, and clinical evidence of pregabalin was demonstrated versus usual care without anti-epileptics. A Markov model was developed to simulate the evolution of a patient cohort over 1-year, and applied cycles of four weeks. During each cycle, patients remained in one out of four possible states: severe, moderate or mild pain, and therapy withdrawal. Both health care-payers and societal perspectives were considered. Clinical data were obtained from a trial comparing usual care plus placebo to usual care plus pregabalin, at either 150, 300, or 300/600mg/day (the latter depending on clinical response). Resulting effects on pain were transformed into transition-probabilities between different pain levels. Cost and SF36 utility data of pain levels were obtained from a 1-month observational study in 88 patients. **RESULTS:** Usual care resulted in a yearly cost of €6200 compared to €6089 for an all dose pregabalin-mix, meaning a cost saving of 111€ per patient. Utility increase was 0.01 for the pregabalin-mix (QALY 0.510 usual care; 0.520 pregabalin-mix). From a societal perspective, usual care resulted in a cost of €14,350 versus €13,984 with pregabalin mix, representing a cost saving of €367. MonteCarlo analysis showed cost savings were not significant. However, the utility gain, albeit small, was statistically significant. **CONCLUSIONS:** A net cost saving with pregabalin was explained by a longer stay of patients in less-costly mild/moderate states, but was not sig-

nificant, hence pregabalin is cost-neutral when compared to current care. On the other hand, utilities showed a significant difference, perhaps explained by their small variance.

PPN6

#### **A UK PHARMACOECONOMIC MODEL OF PARENTERAL PARECOXIB VERSUS OPIOID ANALGESIA FOLLOWING MAJOR SURGERY**

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**OBJECTIVES:** To estimate the clinical and economic consequences of parecoxib sodium versus a parenteral opioid post-surgical pain management strategy in hospital inpatients undergoing selected major surgeries. **METHODS:** We developed a UK model of postsurgical pain management to assess comparative clinical and economic outcomes in persons receiving parecoxib or opioids as a parenteral analgesic regimen. Model parameters were derived from international clinical trial data, a large US hospital billing database, and published literature. The model tracks patient cohorts defined by age and gender over the 3-day period following major abdominal, orthopedic, or gynecologic surgery. The parecoxib regimen included adjunctive use of opioids. The model estimates occurrences of opioid-related symptoms ("clinically meaningful events" or CMEs), time spent in a postanesthesia care unit (PACU) or special care unit (SCU), various pain intensity metrics, and direct medical costs. Model outcomes include differences by treatment regimen (parecoxib versus comparator) in CMEs, PACU/SCU time, pain intensity scores, direct medical costs, and incremental cost-effectiveness ratios. **RESULTS:** Base-case estimated hospitalization costs in the 3 days following surgery were £27 per patient lower among parecoxib- versus opioid-treated patients. Patients receiving parecoxib spent 11 minutes less time, on average, in PACUs and SCUs than opioid-treated patients. Total CMEs were approximately 26% lower among parecoxib- versus opioid-treated patients. Pain intensity scores were uniformly lower (by a range of 26% to 29%) for parecoxib-treated patients versus opioids. Based on model estimates of total cost and values for each of the model outcomes, incremental cost-effectiveness analysis suggests that parecoxib therapy is more effective and less costly than opioid therapy. **CONCLUSIONS:** Results from this model suggest that the opioid-sparing properties of parecoxib translate into better clinical outcomes, reduced health care resource utilization, and lower costs versus an opioid-only pain management strategy.

PPN7

#### **COST-EFFECTIVENESS ANALYSIS OF THE COMBINATION TRAMADOL PLUS PARACETAMOL VERSUS CODEINE PLUS PARACETAMOL FOR POSTOPERATIVE PAIN THERAPY IN THE NETHERLANDS**

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**OBJECTIVES:** In moderate postoperative pain a weak opioid in combination with a non-opioid analgesic is recommended. Corresponding fixed combinations with paracetamol include the weak opioid tramadol or codeine. The objective of this study was to determine the cost-effectiveness of the tramadol/paracetamol combination (Zaldiar®) in comparison to a codeine/paracetamol combination (with a ratio of 1:10; codeine:paracetamol) for postoperative pain after arthroscopic procedures or abdominal